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2001-2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa

Implementation of General Assembly resolution 67/299 on consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2015

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Director General of the World Health Organization submitted in accordance with General Assembly resolution 67/299.

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Report of the Director-General of the World Health Organization

Summary

The present report is submitted in response to General Assembly resolution 67/299, which provides a review of progress in the implementation of the resolution, focusing on the adoption and scaling-up of interventions recommended by the World Health Organization in malaria-endemic countries. It provides an assessment of progress towards the 2015 global malaria targets, including Millennium Development Goal 6, targets set through the African Union and the World Health Assembly and goals set through the Global Malaria Action Plan of the Roll Back Malaria Partnership. It elaborates on the challenges limiting the full achievement of the targets, and provides recommendations to ensure that progress is accelerated up to and beyond 2015.

I. Introduction

1. While malaria is a preventable and treatable disease, it continues to have a devastating impact on people's health and livelihoods around the world. In 2012, approximately 3.4 billion people were at risk of the disease in 97 countries and territories, and an estimated 207 million cases occurred (uncertainty range: 135 million-287 million). The disease killed about 627,000 people (uncertainty range: 473,000-789,000), mostly children under 5 years of age in sub-Saharan Africa. The World Health Organization (WHO) recommends a multi-pronged strategy to reduce the malaria burden, including vector control interventions, preventive therapies, diagnostic testing, quality-assured treatment and strong malaria surveillance.

2. The present report highlights progress and challenges in the control and elimination of malaria in the context of General Assembly resolution 67/299. It draws on recent reports produced by WHO and on contributions made by the Office of the Special Envoy for Financing the Health Millennium Development Goals and for Malaria, the African Leaders Malaria Alliance, the United Nations Children's Fund (UNICEF) and the Roll Back Malaria Partnership. The analysis is based on data received from malaria-endemic countries and a range of organizations supporting global malaria efforts.

3. During the past decade, malaria received worldwide recognition as a priority global health issue. A steep rise in international funding has enabled malaria-endemic countries to greatly expand their efforts to reduce malaria morbidity and mortality. According to WHO estimates, significant reductions have been achieved and the world is on track to achieve the Millennium Development Goal 6 target on malaria. Malaria efforts have also contributed to progress towards Millennium Development Goal 4, improving child survival rates in Africa and around the world. Although international funding increased exponentially between 2004 and 2013, global funding targets to achieve universal coverage of malaria interventions have not been fully met.

4. The success of efforts to control and eliminate malaria is measured through progress made towards a set of global goals and targets, which have been designed through intergovernmental processes or set in the context of global initiatives. There are four main sets of global goals and targets for 2015: Millennium Development Goal 6; targets set through the African Union (the Declaration and Plan of Action on the Roll Back Malaria initiative adopted at the Extraordinary Summit of Heads of State and Government of the Organization of African Unity, held in Abuja in April 2000); targets set through the World Health Assembly; and goals set by the Roll Back Malaria Partnership through the Global Malaria Action Plan. Additional regional and subregional targets for malaria control and elimination are not addressed here.

5. In 2005, the World Health Assembly adopted a resolution in which it set a target of reducing the malaria burden by 50 per cent by 2010, and by 75 per cent between 2000 and 2015. In 2007, the Assembly passed another resolution in which it instituted World Malaria Day on 25 April every year, the day on which African Union countries have commemorated Africa Malaria Day since 2001. The Assembly also called upon member States to halt the provision of oral artemisinin-based monotherapies. In its resolution on malaria adopted in 2011, the Assembly called for

increased efforts to control emerging resistance to antimalarial drugs and insecticides. It also called on member States to keep malaria high on political and development agendas and to undertake strategic reviews of national malaria programmes to optimize national responses.

6. Under the umbrella of the Roll Back Malaria Partnership, endemic countries, United Nations agencies, bilateral donors, public-private partnerships, scientific organizations, academic institutions, non-governmental organizations and the private sector are working together to scale up WHO-recommended interventions, harmonize activities, and improve strategic planning, programme management and funding availability. The Global Malaria Action Plan, released in 2008, was developed collectively to accelerate global efforts to control and eliminate the disease. Its objectives and targets were revised in 2011.

II. Current situation

7. Between 2000 and 2012, a substantial scale-up of malaria interventions led to a 42 per cent decline in malaria mortality rates globally, saving an estimated 3.3 million lives. About 90 per cent, or 3 million, of these lives were saved in children under five in Africa. The under-5 mortality rate that is attributable to malaria in Africa has declined by 54 per cent. Global case incidence has been reduced by 25 per cent globally and by 31 per cent in Africa.

8. The disease remains concentrated in 17 countries, where about 80 per cent of the world's malaria deaths occur. Two countries — the Democratic Republic of the Congo and Nigeria — account for about 40 per cent of malaria mortality worldwide. In South East Asia, the second most affected part of the world, India has the highest malaria burden, followed by Indonesia and Myanmar. Overall, progress in reducing the malaria burden has been faster in countries that had lower rates of transmission in 2000.

Vector control measures

9. The scale-up of insecticide-treated net distribution and indoor residual spraying has been a critical factor in bringing down disease transmission. Between 2004 and 2013, more than 700 million insecticide-treated nets[1] were delivered to countries in Africa, leading to a major increase in household ownership and insecticide-treated net use. Despite this progress, only a few countries have managed to achieve universal coverage with insecticide-treated nets and major disparities remain between countries and across regions. The primary reason for this has been a shortage of funding to procure and distribute enough nets to cover all affected communities.

10. Among 17 African countries surveyed in the period 2010-2012, the proportion of the at-risk population that slept under an insecticide-treated net was under 20 per cent in Cameroon and Zimbabwe while it was over 60 per cent in Madagascar, Rwanda and the United Republic of Tanzania. Some of these disparities may soon

[1] Although WHO recommends the use of long-lasting insecticidal nets, given the continued use of conventional insecticide-treated nets, especially outside Africa, the more generic term "insecticide-treated nets" is used throughout this document.

be narrowed as more than 140 million insecticide-treated nets were delivered to Africa in 2013, and more than 200 million have been funded for delivery in 2014. It is expected that 2014 will be the strongest year for net deliveries since 2000. It is also encouraging that in all countries surveyed, insecticide-treated net coverage is consistently higher in the two most vulnerable groups — children under five and pregnant women — than national averages.

11. Indoor residual spraying is being deployed in 40 countries in Africa, and is used in combination with insecticide-treated nets in 31 of these countries. The proportion of the population protected by indoor spraying in Africa increased substantially in the period 2006-2008 and was maintained during 2009-2011, at 10-12 per cent of the population at risk. By 2012, however, this proportion fell to 8 per cent because of a contraction of spraying programmes in some countries, owing partly to the use of more costly insecticides, which are being deployed to manage emerging mosquito resistance to insecticides. Currently, DDT is used for indoor spraying by six countries in Africa.

12. While current vector control tools remain effective, there is an urgent need to prevent and manage the spread of insecticide resistance, and to develop new tools and new insecticides. Studies have identified resistant mosquitoes in 64 countries around the world, including in most endemic countries in Africa. In 2012, WHO and the Roll Back Malaria Partnership released a Global plan for insecticide resistance management in malaria vectors, which provides tailored guidance to countries, partners and the private sector. A large majority of countries are now undertaking insecticide resistance monitoring but constraints in funding and entomological capacity have slowed progress in the country-based implementation of this plan.

Diagnostic testing and treatment

13. During the past eight years, access to quality-assured antimalarials has been significantly expanded across Africa, helping to treat millions of cases each year, and preventing severe disease and death. Artemisinin-based combination therapies are currently the most effective medicines for uncomplicated malaria caused by the P. falciparum parasite (this is the most lethal malaria parasite and is responsible for the large majority of cases in Africa). Despite the clear WHO recommendation to use combination therapies, oral artemisinin-based monotherapies continue to be available and used in many countries, primarily in the private sector.

14. WHO recommends universal diagnostic testing of all suspected malaria cases when patients seek treatment at health clinics, pharmacies or with community health workers. Between 2010 and 2012, the diagnostic rate in the public sector increased from 37 per cent to 61 per cent, owing to an increased use of microscopy and a sharp rise in the use of rapid diagnostic tests. This has occurred in parallel with a gradual improvement in the quality of rapid diagnostic tests, as demonstrated by the WHO Malaria RDT Product Testing programme, jointly managed by WHO, the United States Centers for Disease Control and Prevention, the Foundation for Innovative New Diagnostics and the Special Programme for Research and Training in Tropical Diseases.

15. Africa accounts for more than 90 per cent of the estimated global need for artemisinin-based combination therapy. In 2011 and 2012, more than 130 million treatment courses were distributed by national malaria control programmes to public

sector health facilities in Africa. In selected countries for which household surveys are available, an estimated 68 per cent of children receiving antimalarials were given artemisinin-based combination therapy. At the same time, a large number of children received artemisinin-based combination therapy to treat fever, suggesting that either malaria diagnostic testing is not being performed, or that the results do not guide malaria treatment. WHO urges countries to strengthen reporting on diagnostic testing and treatment, including on how the two are linked in the case of individual patients.

16. Integrated community case management of malaria and other childhood illnesses can significantly reduce child mortality in rural communities in Africa. WHO and UNICEF have been expanding efforts to scale up integrated community case management programmes, through which community health workers are trained, supplied and supervised to diagnose and treat children under five for malaria, pneumonia and diarrhoea. This equity-focused strategy aims to complement and extend the reach of public health services in rural areas where health infrastructures tend to be the weakest and malaria transmission the highest.

17. Following a recommendation by the United Nations Commission on Life-Saving Commodities for Women's and Children's Health, UNICEF initiated the establishment of a Reproductive, Maternal, Newborn and Child Health Trust Fund in 2013. This provides catalytic and gap-filling financial support to countries to improve access to life-saving commodities and services, including those needed in integrated community case management programmes. In addition, the Global Fund to Fight AIDS, Tuberculosis and Malaria incorporated certain elements of integrated community case management into its new funding model. In early 2014, UNICEF and the Global Fund announced a unified plan, including a memorandum of understanding, to support a scale-up of such activities across Africa.

Preventive therapies

18. Preventive chemotherapies are key elements of the multi-pronged strategy to combat malaria. WHO-recommended preventive therapies include intermittent preventive treatment of pregnant women, intermittent preventive treatment of infants, and seasonal malaria chemoprevention for children under five. These interventions are recommended in areas of moderate to high malaria transmission in sub-Saharan Africa, with seasonal malaria chemoprevention being recommended only in areas of highly seasonal transmission across the Sahel subregion.

19. The uptake of these interventions has been slower than expected. WHO recommends one dose of treatment to be given to pregnant women at each of the four scheduled antenatal visits. According to the latest available survey of 26 countries that reported on this intervention (2012), while about 64 per cent of pregnant women presenting for antenatal care receive a first dose, only about 38 per cent receive two doses, and only 23 per cent receive three doses.

20. To date, seasonal malaria chemoprevention has been adopted by two countries. A further nine countries are finalizing policy adoption, among which several are starting small-scale implementation programmes. The United Nations Children's Fund is actively supporting scale-up of this intervention. Intermittent preventive treatment of infants has been adopted by one country so far and roll-out has not yet started.

Artemisinin resistance

21. The emergence of artemisinin resistance in the Greater Mekong subregion of South East Asia has presented a significant challenge to regional malaria control and elimination efforts. Artemisinin-resistant strains of the disease have been detected in Cambodia, Myanmar, Thailand, Viet Nam, and most recently in the Lao People's Democratic Republic. If resistance were to spread to — or emerge in — India or sub-Saharan Africa, the public health consequences could be dire, as no alternative antimalarial medicine is currently available with the same level of efficacy and tolerability as artemisinin-based combination therapies.

22. Since early in 2013, WHO has been coordinating a multi-stakeholder effort to scale up malaria interventions in the Greater Mekong subregion. A regional hub in Phnom Penh is providing an umbrella for a coordinated effort to respond to country needs. The WHO emergency response plan is being implemented by a consortium of endemic countries, organizations of the United Nations system, and country-based malaria partners. These efforts are built on the foundation of the Global plan for artemisinin resistance containment, which was launched by the WHO Director-General in 2011.

23. Recent years have witnessed growing regional political commitment to address the challenge of artemisinin-resistant malaria. Countries of the Asia and the Pacific, with leadership from Australia and Viet Nam, launched the Asia Pacific Leaders Malaria Alliance at the East Asia Summit in Brunei Darussalam in October 2013. The secretariat of the Alliance is hosted by the Asian Development Bank in Manila. Two high-level task forces have been set up: one on access to quality medicines and other technologies; and the other on regional financing for malaria interventions. In 2013, the Global Fund committed $100 million for three years to help affected countries in the Greater Mekong subregion to intensify malaria control and elimination efforts.

24. Late in 2013, researchers identified a molecular marker associated with delayed parasite clearance in patients given treatment containing artemisinin. The molecular marker could allow for a more precise mapping and monitoring of the geographical distribution and spread of resistance. It could also enable a retrospective mapping of possible resistance in a large number of settings. WHO is currently working with researchers, national malaria programmes and other partners — within and outside the Greater Mekong subregion — to map the presence of artemisinin resistance. Therapeutic efficacy studies will continue to remain a central tool for monitoring the efficacy of nationally recommended antimalarial treatments in all countries.

25. The continued availability and use of oral artemisinin-based monotherapies poses a major risk to malaria control efforts and has contributed to the emergence of artemisinin resistance. WHO has long recommended the withdrawal of oral artemisinin-based monotherapies from the market, and their replacement by artemisinin-based combination therapies (ACTs), as endorsed by the World Health Assembly in 2007. However, these medicines are still marketed by at least 30 companies around the world. Globally, 48 countries have withdrawn marketing authorization for these medicines but 9 countries continue to allow their marketing, including 7 countries in Africa.

Malaria surveillance

26. Globally, the malaria case detection rate has increased from 3 per cent in 2000 to 14 per cent in 2012, which is due primarily to increases in diagnostic testing rates in Africa. Despite these improvements, however, it is not possible to make a reliable assessment of malaria trends in 41 countries, owing to incompleteness or inconsistency of reporting over time, changes in diagnostic practice or health service utilization. There is a critical need to strengthen malaria surveillance in high-burden countries to enable ministries of health to direct resources to populations most in need and to respond effectively to disease outbreaks.

27. In 2012, WHO released operational manuals on surveillance for malaria control and malaria elimination. These manuals, along with the *Manual for universal access to malaria diagnostic testing*, and the *Guidelines for the Treatment of Malaria*, are the core WHO documents that underpin the global initiative known as "T3: Test. Treat. Track." As part of the T3 push, WHO encourages malaria-endemic countries and global malaria partners to scale up diagnostic testing, quality-assured treatment and surveillance to amplify the impact of prevention measures, and further accelerate progress. T3 was launched by the WHO Director-General in April 2012 in Namibia.

Elimination and certification

28. There are 26 malaria-endemic countries around the world that are classified by WHO as being in the pre-elimination, elimination or prevention of reintroduction phases. However, many more countries have declared malaria elimination as a national goal and are starting to reorient their control programmes towards elimination. In recent years, four countries have been certified by WHO as free of malaria: Armenia (2011), Morocco (2010), the United Arab Emirates (2007), and Turkmenistan (2010). Initiatives such as the E8 within the Southern African Development Community are essential to maintaining political momentum around elimination, and driving progress.

29. In many countries nearing elimination, malaria transmission occurs mostly in remote areas, often near international borders, and a high proportion of malaria cases are seen among migrants and mobile populations. In these countries, progress towards elimination will require improved commodity delivery strategies and an expansion of access to health services for affected groups. Strong regional and cross-border collaboration and improvements in diagnostic tools are also essential for sustaining progress. In April 2014, WHO launched a manual on elimination scenario planning to help countries assess the technical, operational and financial feasibility of malaria elimination.

New global guidance from WHO

30. Since the previous progress report on malaria submitted to the General Assembly (A/67/825), WHO has issued guidance documents on the implementation of seasonal malaria chemoprevention; malaria diagnostics in low transmission settings; delayed haemolytic anaemia following treatment with artesunate; achieving universal coverage with long-lasting insecticidal nets; recommended methods for

estimating the longevity of long-lasting insecticidal nets; the combining of indoor residual spraying and long-lasting insecticidal nets; and capacity-building in malaria entomology and vector control.

31. The organization has also issued a global review of evidence and practice on fever management in peripheral health-care settings; a policy brief on the implementation of intermittent preventive treatment of pregnant women; operational manuals on indoor residual spraying and larval source management; an inter-agency field handbook on malaria control in humanitarian emergencies; a series of case studies on malaria elimination; and a number of new training manuals. Many of these documents were produced with support from a range of partners. In addition, each meeting report of the Malaria Policy Advisory Committee, the independent expert group that advises WHO on new policies, has been published in the open-access *Malaria Journal*.

New global technical strategy

32. In 2013, WHO started developing a new global malaria strategy to provide countries with evidence-based technical guidance for the 2016-2025 period. The new global strategy will describe the global direction of malaria efforts over the next decade and set targets and goals beyond 2015, in alignment with new targets currently being discussed as part of the 2015 development agenda. The strategy is being developed under the guidance of the Malaria Policy Advisory Committee and a dedicated steering committee, in consultation with national malaria control programmes.

33. The strategy will provide the technical underpinning for the Roll Back Malaria Partnership's Global Malaria Action Plan 2. The Roll Back Malaria document will focus on how the WHO strategy could best be implemented through global advocacy, resource mobilization, partner harmonization and the engagement of non-health sectors. The steering committees for the two processes have overlapping membership to ensure alignment and coordination. Between February and June 2014, a series of joint technical consultations will have been held in all WHO regions, to which all member States where malaria is endemic have been invited.

Political commitment and accountability

34. In 2013 and 2014, 49 member States in Africa continued to work together under the aegis of the African Leaders Malaria Alliance. African Heads of State and Government convened twice a year for a dedicated malaria forum at the African Union Summit to reaffirm their commitment to defeating malaria. At the most recent forum, in January 2014, seven countries received awards for excellence for maintaining vector control coverage of more than 95 per cent all year round. Progress is tracked through the quarterly African Leaders Malaria Alliance Scorecard on Accountability and Action, and country reports highlighting progress and identifying critical actions needed to sustain the gains.

35. In May 2013, the World Health Assembly reviewed progress on malaria control and elimination. Member States stressed the importance of maintaining malaria as a priority in the post-2015 global health and development agenda, and expressed support for the development of a WHO global technical strategy for

malaria. At a side event during the opening of the sixty-eighth session of the General Assembly, in September 2013, the Roll Back Malaria Partnership and the United Nations Development Programme launched a multisectoral action framework for malaria, which puts forward a vision and a concrete path for addressing the broader socioeconomic determinants of malaria and for engaging key actors from non-health sectors.

36. In July 2013, African Heads of State convened for a special summit in Abuja to commemorate the twelfth anniversary of the African Union Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, held in 2001. The 2013 summit focused on strengthening ownership, accountability and sustainability of HIV/AIDS, tuberculosis and malaria responses. It adopted a new declaration on HIV/AIDS, tuberculosis and malaria, in which Heads of State reaffirmed their commitment to accelerating progress, and pledged to increase domestic resources to strengthen health systems. WHO and partners jointly launched a new initiative — the Malaria Situation Room — to provide strategic support to the highest-burden countries.

37. The Malaria Situation Room is a joint project between WHO, the Roll Back Malaria Partnership Secretariat, the African Leaders Malaria Alliance, the Special Envoy for Financing the Health Millennium Development Goals and for Malaria, and the International Federation of Red Cross and Red Crescent Societies. It is a collaboration that allows key malaria partners to jointly assess operational challenges in the 10 worst-affected countries in Africa, and help countries resolve bottlenecks and accelerate progress towards 2015 goals.

38. In January 2014, the Office of the Special Envoy for Financing the Health Millennium Development Goals and for Malaria launched a road map to speed up progress towards Millennium Development Goal 4, stressing that under-5 deaths needed to be brought down by 2.2 million by the end of 2015 to achieve Goal 4. This followed the announcement in September 2013 of $1.15 billion funding by the World Bank, UNICEF, USAID and the Government of Norway — together with the Special Envoy's Office — which was earmarked for maternal and child health programmes facilitating progress towards Goal 4.

39. The "Promise Renewed" initiative has been endorsed by 176 Governments since its adoption at the Child Survival: Call to Action high-level forum, which was held in Washington, D.C., in June 2012, convened by the Governments of Ethiopia, India and the United States of America in collaboration with UNICEF. The initiative has triggered new commitments to protect the most vulnerable communities in many malaria-endemic countries. For example, Nigeria has launched an initiative to save 1 million lives by 2015 through scaling up access to essential primary health services and commodities for women and children. The Democratic Republic of the Congo has announced a national acceleration framework to significantly reduce maternal and under-5 mortality by 2035. Zambia has unveiled a four-year road map to save an average of 27,000 lives every year.

III. Urgent funding needs

40. While international disbursements expanded 10-fold between 2004 and 2013, available funding is still substantially less than the $5.1 billion that is needed to achieve universal coverage of malaria interventions. International financing for

malaria totalled $1.66 billion in 2011 and $1.94 billion in 2012. Domestic financing has shown a gradual rise and was estimated to be $522 million in 2012, with endemic countries in Africa and in South America committing most resources. Combining domestic and international funds, the resources available for malaria efforts globally were estimated to be just over $2.4 billion in 2012, leaving an annual gap of $2.7 billion.

41. It is hoped that more funding will be available in the next few years. During the Global Fund's fourth replenishment conference, held in Washington, D.C., in December 2013, an initial amount of $12 billion was pledged in contributions from 25 countries, as well as the European Commission, private foundations, corporations and faith-based organizations. While slightly lower than the Global Fund's $15 billion target, this represented the largest amount ever committed to combating AIDS, tuberculosis and malaria. Given that approximately 60 per cent of all international funding for malaria is being disbursed by the Global Fund, it is critical that donors maintain a high level of commitment to this strategic investment vehicle.

42. During 2012 and 2013, the Global Fund underwent a major reform and restructuring process, which led to the development of a new funding model that moves away from the round-based system and gives malaria-endemic countries more flexibility with regard to the alignment of funding with national malaria strategies. Under the new funding model, launched in March 2014, the Global Fund will focus more strongly on countries with the highest burden of disease and the least ability to provide domestic financing, thereby ensuring greater equity in access to international funds. A separate resource envelope has been created to reward high-impact, well-performing programmes.

43. In December 2013, the World Bank Group's International Development Association fund also had a record replenishment, with $52 billion pledged. The International Development Association is one of the world's largest sources of aid, providing zero- to low-interest credits and grants for investments in health and education, infrastructure and agriculture, and economic and institutional development to the least developed countries, 40 of them in Africa. Both the Global Fund and World Bank funding cycles will span the target date for the Millennium Development Goals and the launch of the post-2015 agenda — a pivotal crossroad in the global effort to reduce the burden of infectious diseases.

IV. Progress towards global goals and targets

44. The success of efforts to control and eliminate malaria is measured through progress made towards a set of 2015 targets, which have been designed through intergovernmental processes or set in the context of global initiatives. Progress is summarized each year by WHO in the *World Malaria Report*, which provides a comprehensive overview of trends in programme financing, intervention coverage and malaria cases and deaths. Data are received from national malaria control programmes in endemic countries — via WHO Regional Offices — and are complemented by information received through household surveys, notably demographic and health surveys, multiple indicator cluster surveys and malaria indicator surveys.

45. Assessing the progress made by individual countries towards global targets has been challenging as surveillance systems in high-burden countries in Africa detect only a fraction of the actual malaria cases and deaths. In 41 malaria-endemic countries around the world — 32 of which are in Africa — an assessment of malaria trends can only be made using burden estimation methods that rely on a modelled relationship between malaria transmission, intervention coverage and case incidence or mortality.

Millennium Development Goal 6

46. Malaria control and elimination is covered by Millennium Development Goal 6, target 6.C to "have halted by 2015 and begun to reverse the incidence of malaria and other major diseases". Given that malaria accounts for 7 per cent of under-five mortality globally, it is also central to achieving Goal 4, target 4.A "to reduce by two thirds, between 1990 and 2015, the under-five mortality rate". Global malaria efforts are also making a contribution to the achievement of Goals 1, 2, 3, 5 and 8.

47. An assessment of global malaria trends between 2000 and 2012 indicates that the world is on track to achieve Goal 6, target 6.C. Between 2000 and 2012, malaria incidence rates — which take into account population growth — were reduced by 25 per cent globally, and by 31 per cent in Africa. The malaria mortality rate decreased by 42 per cent worldwide during the same period, and the decline in Africa was 49 per cent. This progress can be sustained only if interventions continue to be scaled up, robust control operations are implemented in all high-burden countries, and resurgences and outbreaks are prevented.

48. Based on reported data, 59 countries around the world are on track to achieve a reversal of malaria incidence and are therefore meeting Goal 6. Progress towards the target is also monitored through an analysis of the coverage of children under five years of age with prevention and treatment interventions, in particular the use of insecticide-treated nets and the percentage of cases treated with an artemisinin-based combination therapy. While universal coverage continues to remain a distant target for most countries, the past few years have witnessed a major expansion of access to both malaria prevention and treatment.

49. The number of insecticide-treated nets delivered to endemic countries in Africa increased consistently between 2004 and 2013, with only three years (2007, 2011 and 2012) showing a drop. The proportion of households in sub-Saharan Africa owning at least one net reached 56 per cent in 2012 but declined slightly, to 54 per cent. in 2013. Meanwhile, the proportion of the at-risk population sleeping under an insecticide-treated net (representing the population directly protected) was 36 per cent in 2013. The proportion of children under five years old sleeping under a net was slightly higher, 40 per cent. Overall, this scale-up has translated into an expanding coverage of at-risk populations with nets but major gaps remain.

50. While the sales of artemisinin-based combination therapy have expanded substantially around the world, reliable data are not available about the utilization of these antimalarials in the public and private sectors. In selected countries for which household surveys are available, an estimated 68 per cent of children receiving antimalarials were given artemisinin-based combination therapy. At the same time, a large number of children received artemisinin-based combination therapy to treat fever, suggesting that malaria diagnostic testing is not being performed, or that the results do not guide malaria treatment.

Abuja targets

51. By adopting the Abuja Declaration on Roll Back Malaria in Africa, and its plan of action, in April 2000, leaders of malaria-endemic countries in Africa committed themselves to halving malaria mortality by 2010, later extending the target to 2015. The Abuja Declaration also contained a commitment to reducing or waiving taxes and tariffs on imported antimalarial medicines, insecticide-treated nets and other essential malaria commodities. In 2006, the Declaration was complemented by the Abuja call for accelerated action towards universal access to HIV/AIDS, tuberculosis and malaria services in Africa.

52. According to the *World Malaria Report 2013*, 10 malaria-endemic countries in Africa are on track to meet the Abuja target of reducing the malaria burden by more than 50 per cent by 2015. Progress towards this target is measured through an analysis of trends in malaria incidence rates. Eight countries (Botswana, Cabo Verde, Eritrea, Namibia, Rwanda, Sao Tome and Principe, South Africa and Swaziland) have already reached this target, having reduced their case incidence rates by more than 75 per cent. Ethiopia and Zambia are projected to reach the 50 per cent target by 2015. In other African countries, it is not possible to reliably assess trends in malaria incidence owing to incompleteness or inconsistency in reporting.

53. The African Leaders Malaria Alliance, in collaboration with WHO and the Roll Back Malaria Partnership, continued to produce a quarterly Scorecard for Accountability and Action, tracking progress against a set number of indicators in all malaria-endemic countries in Africa. In the course of 2013, the scorecard was revised. Indicators on taxes and tariffs were removed, and the list of indicators on maternal and child health were expanded. African Heads of State and Government used the scorecard to review progress at the African Leaders Malaria Alliance forum, held twice a year in partnership with the African Union.

World Health Assembly targets

54. In 2005, the World Health Assembly set the target of reducing the malaria burden by 50 per cent between 2000 and 2010, and by 75 per cent by 2015. According to the *World Malaria Report 2013*, 52 of the 103 countries and territories that had ongoing malaria transmission in 2000 are on track to achieve a 75 per cent reduction in malaria incidence rates by 2015. Eight of these countries are in Africa. While this represents tremendous progress, these countries account for only 4 per cent (8 million) of the malaria cases that are estimated to occur around the world. Globally, malaria incidence rates were reduced by 25 per cent between 2000 and 2012, while the decline in Africa was 31 per cent. To achieve faster progress towards this target, efforts need to be substantially expanded in the 17 highest burden countries, which account for an estimated 80 per cent of malaria mortality.

Global Malaria Action Plan goals

55. The Roll Back Malaria Partnership's Global Malaria Action Plan was launched in 2008 as part of a global advocacy drive to catalyse support for malaria control and elimination, and to rally partners around a common plan of action to combat the disease. The objectives of the Plan, as revised in 2011, were to reduce global malaria deaths to near zero by the end of 2015, to reduce global malaria cases by 75 per cent by end-2015, and to eliminate malaria by end-2015 in 10 new countries (since 2008) and in the WHO European region. The Roll Back Malaria Partnership called for an estimated $5.1 billion annually to ensure universal coverage of malaria interventions. Those funding targets could not be fully achieved, partly because of the decrease in available global health and development funding, triggered by the global financial crisis.

56. As figures cited above have shown, there has been steady progress towards all these ambitious goals. To move closer to attaining the first two goals of the Plan, an urgent and significant expansion of malaria financing would be required, in particular in the highest burden countries. With regard to the third goal, eight new countries (within and outside the European region) have reduced local malaria transmission to zero since 2008 (Argentina, Egypt, Georgia, Iraq, Kyrgyzstan, Russian Federation, Syrian Arab Republic and Uzbekistan) and three others have been certified as free of malaria since 2008 (Armenia, Morocco and Turkmenistan). With local transmission confined to three countries in 2012 (Azerbaijan, Tajikistan and Turkey), the WHO European region is generally on track to reduce local malaria cases to zero by 2015.

V. Recommendations

57. **Member States are urged to step up malaria control and elimination efforts and address the priority actions that have been highlighted by the General Assembly in its resolution 67/299. It is imperative that they maintain a high level of political commitment to reducing the suffering and loss of life caused by malaria. The scale-up of high-impact malaria reduction strategies, and a gradual elimination of the disease should remain a key priority for global health and development beyond 2015.**

58. **Endemic countries should make a concerted effort to put in place mechanisms and devise strategies to achieve universal coverage of malaria interventions. The expansion of malaria interventions can be used as an entry point for strengthening health systems, including maternal and child health services and laboratory services, and to build stronger health information and disease surveillance systems. A further scale-up of integrated community case management in the highest burden countries, and a strengthening of integrated delivery systems for malaria prevention tools, would be a cost-effective solution to help bridge systems gaps until health infrastructures are further strengthened.**

59. **There is an urgent need to increase the availability of financing for malaria efforts through both traditional and innovative financing tools to alleviate suffering in the 17 highest-burden countries, which account for an estimated 80 per cent of malaria mortality. Only through substantial scale-up**

and sustaining of coverage can Africa's worst-affected countries prevent malaria resurgences and move closer towards achieving global targets. Adequate and predictable financing is essential for recent successes to be protected. If countries were to fall back on existing levels of intervention coverage, that could quickly erase much of the gains and investments that have been dedicated to this cause.

60. Endemic countries are urged to maintain, and if possible, increase the domestic resources they make available to combat the disease. It is also recommended that they review and strengthen national strategic plans in line with WHO technical recommendations, and embed those firmly in national health sector and development plans. To achieve a better impact and to ensure that successes are sustained, countries should increasingly adopt a multisectoral approach to combating the disease, and build on synergies with other development priorities.

61. Global development partners and endemic countries should strengthen efforts to address emerging biological threats to malaria control. Parasite resistance to artemisinin can be prevented through implementation of WHO recommendations in the Global plan for artemisinin resistance containment. Strong political commitment is required to launch a coordinated and renewed effort to phase out the use of oral artemisinin-based monotherapies and to remove from markets antimalarial medicines not meeting WHO prequalification standards. The spread of insecticide resistance can be controlled through the adoption of the recommendations contained in the Global plan for insecticide resistance management in malaria vectors.

62. There is a critical need to strengthen malaria surveillance and data quality in all endemic regions to enable ministries of health to direct financial resources to populations most in need, and to respond effectively to disease outbreaks. Given the plethora of partners on the ground, mechanisms for country-based coordination of technical assistance should be strengthened to achieve alignment over the best approaches to implement WHO technical guidance. Additional financing is needed to support the sharing and analysis of best practices to address urgent programmatic challenges, to improve monitoring and evaluation, and to conduct regular financial planning and gap analysis. Further improvement in cross-border and regional collaboration is also imperative.

63. The contribution of the scientific community and the private sector remains essential: new products such as improved diagnostic tools, efficacious medicines, an effective vaccine, new insecticides and more durable insecticide-treated nets are all fundamental to ensuring sustained progress in efforts to combat the disease. The remarkable progress against malaria can be maintained only through a concerted and focused multistakeholder effort, built on the foundation of global political commitment, continuous scientific advancement and vigorous innovation. An effective global partnership under the umbrella of the Roll Back Malaria Partnership will continue to be fundamental to making progress in the run-up to and beyond 2015.